ADVANCED PRACTICE REGISTERED NURSE SPECIALTY FORM

The advanced registered nurse must complete this portion of the form and forward it to his/her professional organization:

Applicant's Name:_____

Please print or type complete name

Applicant's Address: _____

_____

Certification Category:

( ) Nurse Anesthetist
( ) Nurse Midwife
( ) Nurse Practitioner
( ) Clinical Nurse Specialist

TO BE COMPLETED BY THE PROFESSIONAL ORGANIZATION AND RETURNED WITH AFFIXED SEAL TO DOH ON BEHALF OF THE DISTRICT OF COLUMBIA BOARD OF NURSING.

This is to certify that the applicant is currently an active member in good standing of this association. The following information is provided to the Board:

_____

Identification/Certification Number — Dates of Membership (From-To)

Has applicant's certification ever been suspended or revoked by your organization?_____
If yes, please attach statement.

On behalf of the _____, I certify that the above statements are correct.

(SEAL)

_____
Name (print or type)

_____
Title

_____
Date

_____
Telephone Number